

Mental Health Center INSPECTION REPORT

Health and Human Services Regulation & Licensure
CREDENTIALING DIVISION
P.O. BOX 94986
LINCOLN, NEBRASKA 68509
(402) 471-2117

Applicant must demonstrate the capability to meet the Standards of Operation, Care and Treatment as prescribed in 175 NAC 19-006

Type of Inspection: INITIAL LICENSURE - Inpatient

Facility: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

Owner: _____

Sample Inspection Form

Regulatory Citation	Met	Not Met	Comments
19-006.01 Licensee Responsibilities a. Designated administrator who is responsible for the day to day management of the facility; b. Defined written duties and responsibilities of the administrator.			a. Name of Administrator:
			b.
19-006.02 Administration a. Administrator on the premise a sufficient number of hours to permit adequate attention to the management of the mental health center b. Designate a substitute c. Procedures developed for reporting evidence of abuse, neglect, or exploitation of any client served by the facility in accordance with <u>Neb. Rev. Stat. Section 28-732 of the Adult Protective Services Act</u> or in the case of a child, in accordance with <u>Neb. Rev. Stat. Section 28-711.</u>			a. Number of hours Administrator employed:
			b.
			c.
19-006.03 Staff Requirements a. Evidence of each staff having the appropriate license, certification, registration, or credential in order to provide services. b. Established policy and procedure to assure each staff who provide direct care or treatment, has a health screening prior to assuming job responsibilities. c. Process in place for orientation of staff. 1. Client rights; 2. Job responsibilities relating to care and treatment programs and client interactions; 3. Emergency procedures including information regarding availability and notification; 4. Information on any physical and mental special needs of the clients of the facility; and 5. Information on abuse, neglect, and misappropriation of money or property of a client and the reporting procedures. d. System for maintaining written documentation to support facility decisions regarding staffing, staff credentials, staff health status, staff orientation, and ongoing staff training.			a.
			b.
			c.
			d.

➔ I have had this Inspection Report explained to me and understand what corrections must be made, if any, in order to comply with the 175 NAC 19-006.

Date of Inspection: _____

Inspection Rating:

☐ PASS

☐ FAIL

Facility Representative's Signature _____

Surveyor's Signature _____

19-006.04	Client Rights Admission documentation which includes a copy of Client Rights (must contain all 17). 1. To be informed in advance about care and treatment and of any changes in care and treatment that may affect the client's well-being; 2. To self-direct activities and participate in decisions regarding care and treatment; 3. To confidentiality of all records, communications, and personal information; 4. To voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; 5. To examine the results of the most recent survey of the facility conducted by representatives of the Department; 6. To privacy in written communication including sending and receiving mail consistent with individualized service plans; 7. To receive visitors as long as this does not infringe on the rights and safety of other clients and is consistent with individualized service plans; 8. To have access to a telephone where calls can be made without being overheard when consistent with individualized service plans; 9. To retain and use personal possessions, including furnishings and clothing as space permits, unless to do so would infringe upon the rights and safety of other clients; 10. To be free of restraints except when provided as in 175 NAC 19-006.12; 11. To be free of seclusion in a locked room, except as provided in 175 NAC 19-006.12; 12. To be free of physical punishment; 13. To exercise his or her rights as a client of the facility and as a citizen of the United States; 14. To be free from arbitrary transfer or discharge; 15. To be free from involuntary treatment, unless the client has been involuntarily committed by appropriate court order; 16. To be free from abuse and neglect and misappropriation of their money and personal property; and 17. To be informed prior to or at the time of admission and during stay at the facility of charges for care, treatment, or related charges.			
19-006.05	Complaints/Grievances a. Established written procedures for addressing complaints and grievances from clients, staff, and others b. Procedure for submission of complaints and grievances available to clients, staff, & others c. Mechanism or document to ensure that the telephone number and address of the Department is readily available to clients, staff, and others who wish to lodge complaints and grievances.			a.
				b.
				c.
19-006.06	Facility House Rules a. Developed house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies and smoking. b. consistent with client rights. c. posted in an area readily accessible to clients.			a.
				b.
				c.

Facility Name:

Met	Not Met
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19-006.07	Quality Assurance/Performance Improvement a. System to conduct an ongoing comprehensive, integrated assessment of the quality and appropriateness of care and treatment provided.			
19-006.08	Care and Treatment Requirements a. Written program description that is available to staff, clients, and members of the public that explains the range of care and treatment activities provided, which includes: goals and objectives; 1. Specific care and treatment activities provided by the facility; 2. Availability of staff to provide care and treatment activities, including job responsibilities for meeting care and treatment needs of client population; 3. Characteristics of the persons to be served; 4. Staff composition and staffing qualification requirements; 5. Admission and discharge processes, including criteria for admission and discharge; 6. Referral mechanisms for services outside the facility; 7. The client admission and ongoing assessment and evaluation procedures used by the facility, including individualized service plan process; 8. Plan for providing emergency care and treatment, including use of facility approved interventions to be used by staff in an emergency situation; 9. Quality assurance/performance improvement process, including who will be responsible for the program and how results will be utilized to improve care and treatment; and 10. System governing the reporting, investigation, and resolution of allegations of abuse, neglect and exploitation. b. Established policies and procedures to implement the facility's program as described in #a above (175 NAC 19-006.08A.)			a.
				b.
19-006.09	Admission and Retention of Clients a. Written criteria for admission that includes each level of care and the components of care and treatment provided by the facility. The written criteria must include how eligibility for admission is determined based on: 1 Identification of client need for care and treatment, including the severity of the presenting problem; 2 Rationale for determining appropriate level of care and treatment; and 3 Need for supervision and other issues related to providing care and treatment. b. Must provide an orientation to each new client that includes an explanation o facility house rules, client rights, fee policy, conditions under which residency would be terminated and a general description of available activities. c. Evidence to ensure that the client orientation will be completed within 24 hours of admission.			a.
				b.
				c.

Facility Name:

		Met	Not Met
19-006.10	Care and Treatment Provided a. Procedures to ensure the facility provides care and/or treatment to meet client needs on an ongoing basis in a manner that respects clients' rights, promotes recovery and affords personal dignity as: 1. Provision of adequate shelter and arrangements for food and meals; 2. Provision of care and treatment to meet client identified needs; 3. Medical and clinical oversight of client needs as identified in the client assessment; 4. Assistance with acquiring skills to live as independently as possible; 5. Assistance and support, as necessary, to enable clients to meet personal hygiene and clothing needs; 6. Assistance and support, as necessary, to enable clients to meet their laundry needs, which includes access to washers and dryers so that clients can do their own personal laundry; 7. Assistance and support, as necessary, to enable clients to meet housekeeping needs essential to their health and comfort, including access to materials needed to perform their own housekeeping duties; 8. Activities and opportunities for socialization and recreation both within the facility and in the community; 9. Health-related care and treatment; and 10. Assistance with transportation arrangements.		
19-006.11	Mental Health Services a. Evidence or protocols to assure the facility arranges for access to mental health services on a routine and ongoing basis to meet the identified client needs; and that the facility assists the client in keeping appointments and participating in treatment programs.		a.
	b. Evidence to assure that the facility arranges for licensed mental health professional services consistent to meet client population served and individual client needs on an ongoing basis.		b.
	c. Evidence to assure the facility makes arrangements for care of client emergencies on a 24 hour, 7 day a week basis. Arrangements must include the following: 1. Access to qualified facility staff trained to handle psychiatric behaviors who must be available to provide care and treatment; 2. Plan for provision of emergency treatment, including circumstances when restraint use may be necessary and how facility staff will respond; and 3. Plan to provide safety to clients who pose an imminent danger to themselves or others, which may include transfer to an appropriate facility.		c.
19-006.12	Restraints and Seclusion <u>a. Secured Environment Facility:</u> A mental health center that provides a secured and protective environment by restricting a client's exit from the facility or its grounds through the use of approved locking devices on exit doors or other closures must be accredited by an approved qualifying organization.		a. Name of Accrediting Agency: JCAHO / CARF / COA

Facility Name:

Met Not Met

19-006.12 Continued	<p>b. Accredited Facilities: A mental health center that is accredited by an approved qualifying organization may use restraint and seclusion methods as part of a client's treatment plan. Evidence of compliance with approved qualifying organization's requirements for initiation and continued use of restraint and seclusion.</p>			b. Name of Accrediting Agency: JCAHO / CARF / COA
	<p>c. Non-Accredited Facilities: A non-accredited mental health center is prohibited from using mechanical and chemical restraints and seclusion. The facility must establish alternative and less restrictive methods for staff to use in the place of restraints and seclusion to deal with client behaviors. A non-accredited mental health center may use manual restraint and/or time out as therapeutic techniques only after it has:</p> <ol style="list-style-type: none"> 1. Written policies and procedures for the use of manual restraint and time-out; 2. Documented physician approval of the methods used by the facility; 3. Trained all staff who might have the occasion to use manual restraints and/or time-out in the appropriate methods to use in order to protect client safety and rights; and 4. Developed a system to review each use of manual restraint or time-out. The facility must ensure the review process includes the following requirements: 5. That each use of manual restraint or time-out be reported to the administrator for review of compliance with facility procedures; and 6. That documentation of each use of manual restraint or time-out include a description of the incident and identification of staff involved. <p>A non-accredited mental health center may use manual restraint and/or time out as therapeutic techniques only in the following circumstances:</p> <ol style="list-style-type: none"> 1. An emergency situation where the safety of the client or others is threatened; 2. The implementation and failure of other less restrictive behavior interventions; and 3. Use of manual restraint and/or time out only by staff who are trained as described in 175 NAC 19-006.12C1, item 3. 			c.
19-006.13	<p>Client Assessment Requirements: Evidence or prepared documents that show the facility will complete the following assessments prior to the development of the individualized service plan:</p> <ol style="list-style-type: none"> 1. Assessments of current functioning according to presenting problem including community living skills, independent living skills and emotional psychological health; 2. Basic medical history and information, determination of the necessity of a medical examination or the results of the medical examination; 3. Current prescribed medications and, if available, history of medications used; and 4. Summary of prior mental health treatment and, if available, service system involvement. 			

19-006.14	<p>Individualized Service Plan Evidence/procedures that the facility develops, within 30 days of admission for each client, a written plan which is based on admission assessment and ongoing assessment information. The individualized service plan must be in writing and include the following:</p> <ol style="list-style-type: none"> 1. Client's name; 2. Date of development of the plan; 3. Specified client care and treatment needs to be addressed including therapeutic activities, behavioral concerns, self-care, physical and medical needs, and medication regimen; 4. Client goals related to specified needs identified that are to be addressed; 5. Interventions addressing the plan goals and who will be responsible for ensuring interventions are carried out as planned; 6. Documentation of client participation in the planning process; 7. Planned frequency and identification of contacts; and 8. Documentation of collaboration with the primary mental health professional in development of the individualized service plan. <p>b. Procedures to ensure that the individualized service plan is reviewed every 6 months and revised as necessary to ensure current client needs are being addressed on an ongoing basis</p>			
19-006.15	<p>Supportive Services Documentation to support that the facility knows about services provided by other agencies and ensure that there is coordination with those agencies in the provision of care and treatment to each client. The care and treatment activities provided by other agencies must be included in each client's individualized service plan.</p>			
19-006.16	<p>Health Management <u>a. Health Management:</u> The facility must ensure that each client is offered medical attention when needed. Evidence that arrangements for health services will be made with the consent of the client and/or designee. <u>b. Admission Health Screening:</u> Evidence that each client will have a health screening, which includes evaluation for infectious disease, within 30 days of admission unless the client has had a physical examination by a licensed practitioner within 90 days prior to admission. <u>c. Regular Health Screenings:</u> Evidence that the facility will ensure that each client has access to a qualified health care professional who is responsible for monitoring his/her health care. Regular health screenings must be done in accordance with the recommendations of the qualified health care professional. <u>d. Emergency Medical Services:</u> Evidence of a written, detailed plan to access medical emergency services as a timely response to client emergencies. <u>e. Supervision of Nutrition:</u> Evidence that the facility will monitor clients assessed as having nutritional needs and provide appropriate care, treatment or referral to meet the identified nutritional needs.</p>			a.
				b.
				c.
				d.
				e.

19-006.16 continued	<p><u>f. Administration of Medication:</u> Established policies and procedures to ensure that clients receive medications only as legally prescribed by a medical practitioner in accordance with the five rights and with prevailing professional standards.</p> <p><u>1. Self-administration of Medications:</u> Clients may be allowed to self-administer medications, with or without supervision, when the facility determines that the client is competent and capable of doing so and has the capacity to make an informed decision about taking medications in a safe manner. The facility must develop and implement policies to address client self-administration of medication, including:</p> <ul style="list-style-type: none"> • Storage and handling of medications; • Inclusion of the determination that the client may self-administer medication in the client's individualized service plan; and • Monitoring the plan to assure continued safe administration of medications by the client. <p><u>2. Licensed Health Care Professional:</u> When the facility uses a licensed health care professional for whom medication administration is included in the scope of practice, the facility must ensure the medications are properly administered in accordance with prevailing professional standards.</p> <p><u>3. Provision of Medication by a Person other than a Licensed Health Care Professional:</u> When the facility uses a person other than a licensed health care professional in the provision of medications, the facility must follow 172 NAC 95, Regulations Governing the Provision of Medications by Medication Aides and Other Unlicensed Persons and 172 NAC 96, Regulations Governing the Medication Aide Registry. The facility must establish and implement policies and procedures:</p> <ul style="list-style-type: none"> • To ensure that medication aides and other unlicensed persons who provide medications are trained and have demonstrated the minimum competency standards specified in 172 NAC 96-004; • To ensure that competency assessments and/or courses for medication aides and other unlicensed persons are provided in accordance with the provision of 172 NAC 96-005. • That specify how direction and monitoring will occur when the facility allows medication aides and other unlicensed persons to perform the routine/acceptable activities authorized by 172 NAC 95-005 and as follows: <ul style="list-style-type: none"> i. Provide routine medication; and ii. Provide medications by: <ul style="list-style-type: none"> ♦ Oral which includes any medication given by mouth including sublingual (placing under the tongue) and buccal (placing between the cheek and gum) routes and oral sprays; ♦ Inhalation which includes inhalers and nebulizers, including oxygen given by inhalation; ♦ Topical applications of sprays, creams, ointments, and lotions and transdermal patches; ♦ Instillation by drops, ointments, and sprays into the eyes, ears, and nose. 			f.
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		Met	Not Met
19-006.16 continued	<ul style="list-style-type: none"> That specify how direction and monitoring will occur when the facility allows medication aides and other unlicensed persons to perform the additional activities authorized by 172 NAC 95-009, which include but are not limited to: <ul style="list-style-type: none"> provision of PRN medication; provision of medications by additional routes including but not limited to gastrostomy tube, rectal, and vaginal; and/or documented in client records. That specify how competency determinations will be made for medication aides and other unlicensed persons to perform routine and additional activities pertaining to medication provision. That specify how written direction will be provided for medication aides and other unlicensed persons to perform the additional activities authorized by 172 NAC 95-009. That specify how records of medication provision by medication aides and other unlicensed persons will be recorded and maintained. That specify how medication errors made by medication aides and other unlicensed persons and adverse reactions to medications will be reported. The reporting must be: <ul style="list-style-type: none"> Made to the identified person responsible for direction and monitoring; Made immediately upon discovery; and Documented in client records. When the facility is not responsible for administration or provision, the facility must maintain responsibility for overall supervision, safety, and welfare of the client. <p><u>g. Reporting of Medication Errors:</u> policies and procedures for reporting any errors in administration or provision of prescribed medications. Any variance from the five rights must be reported as an error:</p> <ol style="list-style-type: none"> To the client's licensed practitioner; In a timely manner upon discovery; and By written report. <p><u>h. Storage of Medication:</u> All medications must be stored in locked areas and stored in accordance with the manufacturer's instructions for temperature, light, humidity, or other storage instructions.</p> <p><u>i. Access to Medication:</u> Evidence to ensure that only authorized staff who are designated by the facility to be responsible for administration or provision of medications have access to medications.</p> <p><u>j. Medication Record:</u> The facility must maintain records in sufficient detail to assure that:</p> <ul style="list-style-type: none"> Clients receive the medications authorized by a licensed health care professional; and The facility is alerted to theft or loss of medication. <p>Evidence that each client has an individual medication administration record which must include:</p> <ul style="list-style-type: none"> Identification of the client; 		<p>g.</p> <p>h.</p> <p>i.</p> <p>j.</p>

Facility Name:

		Met	Not Met	
19-006.16 continued	<ul style="list-style-type: none"> Name of the medication given; Date, time, dosage and method of administration for each medication administered or provided; and the identification of the person who administered or provided the medication; and Client's medication allergies /sensitivities, if any. <p>k. Disposal of Medications: Medications that are discontinued by the licensed health care professional and those medications which are beyond their expiration date, must be destroyed. The facility must develop and implement policies and procedures to identify who will be responsible for disposal of medications and how disposal will occur within the facility.</p> <p>l. Medication Provision during Temporary Absences: When a client is temporarily absent from the facility, the facility must put medication scheduled to be taken by the client in a container identified for the client.</p>			<p>k.</p> <p>l.</p>
19-006.17	<p>Food Service</p> <p>a. Procedures to ensure food is of good quality, properly prepared, and served in sufficient quantities and frequency to meet the daily nutritional needs of each client. Evidence that clients receive special diets when ordered by a licensed health care professional. Foods must be prepared in a safe and sanitary manner.</p> <p>1. Menus: Evidence to ensure that:</p> <ul style="list-style-type: none"> Meals and snacks are appropriate to the clients needs and preferences. A sufficient variety of foods must be planned and served in adequate amounts for each client at each meal. Menus must be adjusted for seasonal changes. Written menus are based on the Food Guide Pyramid or equivalent and modified to accommodate special diets as needed by the client. Records of menus as served are maintained for a period not less than 14 days. <p>b. Client Involvement in Food Service: If clients are involved in the food service of the facility, evidence that each client is trained so that nutritional adequacy and food safety standards are observed.</p>			<p>a.</p> <p>1.</p> <p>b.</p>
19-006.18	<p>Record Keeping Requirements</p> <p>a. Record Keeping: Evidence to ensure the facility must maintain complete and accurate records to document the operation of the facility and care and treatment of the clients.</p> <p>b. Client Records: Evidence that a record will be established for each client upon admission. Each record must contain sufficient information to identify clearly the client, to justify the care and treatment provided and to document the results of care and treatment accurately. Each record must contain, when applicable, the following information:</p> <ol style="list-style-type: none"> Dates of admission and discharge; Name of client; Gender and date of birth; Demographic information, including address and telephone number; Physical description or client photo identification; Admission assessment information and determination of eligibility for admission; Health screening information; Individualized service plans; 			<p>a.</p> <p>b.</p>

Facility Name:

		Met	Not Met
19-006.18 Continued	<p>9. Physician orders;</p> <p>10. Medications and any special diet;</p> <p>11. Significant medical conditions;</p> <p>12. Allergies;</p> <p>13. Person to contact in an emergency, including telephone number;</p> <p>14. Fee agreement;</p> <p>15. Documentation of care and treatment provided, client's response to care and treatment, change in condition and changes in care and treatment;</p> <p>16. Discharge and transfer information;</p> <p>17. Client rights; and</p> <p>18. Referral information.</p> <p><u>c. Client Record Organization:</u> Records are systematically organized to ensure permanency and completeness. Evidence that:</p> <ul style="list-style-type: none"> • <u>Record Entries:</u> All record entries must be dated, legible and indelibly verified. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent. • <u>Confidentiality:</u> The facility must keep records confidential unless medically contraindicated. Records are subject to inspection by authorized representative of the Department. • <u>Retention:</u> Client records must be retained for a minimum of two years. • <u>Access:</u> Client information and/or records may be released only with the consent of the client or client's designee or as required by law. When a client is transferred to another facility or service, appropriate information must be sent to the receiving facility or service. 		c.
19-006.19	<p>Discharge/Transfer Requirements</p> <p><u>a. Discharge/Transfer Criteria:</u> Written discharge criteria which is used by the facility administrator or designee to determine appropriate discharge or transfer for each client. The criteria establishing basis for discharge must include:</p> <ol style="list-style-type: none"> 1. Client no longer needs or desires services provided at the facility; 2. Client requires services or treatment not available at the facility; 3. Client behavior poses a threat to the health or safety of him or herself or to others and cannot be addressed with care and treatment available at the facility; 4. Nonpayment of fees in accordance with fee policy; and 5. Client violates house rules resulting in significant disturbance to other clients or members of the community. <p><u>b. Discharge Plan:</u> Procedures/document to ensure that within the first 30 days of admission a discharge plan must be developed including:</p> <ol style="list-style-type: none"> 1. Plan for follow up or continuing care; and 2. Documentation of referrals made for the client. <p><u>c. Discharge Summary:</u> Procedures/document to ensure the facility documents a summary in the client record which includes description of client's progress under the individualized service plan and reason(s) for discharge or transfer from the facility.</p> <p><u>d. Transfer:</u> Evidence to ensure the timely transfer</p>		

Facility Name:

		Met	Not Met	
	of appropriate client record information as authorized by the client or designee by a signed release of information.			

Facility Name:

Met Not Met

19-006.20	Infection Control a. System for management of identified infections within the facility for clients and staff, which includes the use of standard precautions for prevention of transmission of infectious diseases among clients and/or staff.			
19-006.21	Safety Plan a. System to identify and prevent the occurrence of hazards to clients. Examples of hazards to be identified and prevented are: dangerous substances, sharp objects, unprotected electrical outlets, extreme water temperatures, and unsafe smoking practices.			
19-006.22	Environmental Services <u>Housekeeping and Maintenance</u> a. Facility's buildings and grounds must be kept clean, safe and in good repair. b. All garbage and rubbish must be disposed of in a manner as to prevent the attraction of rodents, flies, and all other insects and vermin. Garbage and rubbish must be disposed in a manner as to minimize the transmission of infectious diseases and minimize odor. c. Provide and maintain adequate lighting, environmental temperatures and sound levels in all areas that are conducive to the care and treatment provided. d. Maintain and equip the premises to prevent the entrance, harborage, or breeding of rodents, flies, and all other insects and vermin. e. Provide equipment, fixtures and furnishings and maintain these things so they are clean, safe and in good repair. <u>Equipment, Fixtures, Furnishings</u> f. must provide equipment adequate for meeting needs as specified in each client's individualized service plan. g. Must have common area and client sleeping area with comfortable beds, chairs, sofas, tables, etc. h. Must establish and implement a process designed or routine and preventative maintenance of equipment and furnishings to ensure that the equipment and furnishings are safe and functions to meet their intended use. <u>Linens</u> i. The inpatient facility must provide each client with an adequate supply of clean bed, bath, and other linens as necessary for care and treatment. Linens must be in good repair. <ul style="list-style-type: none"> Established procedures for the storage and handling of soiled and clean linens. j. When the facility provides laundry services, water temperatures to laundry equipment must exceed 160 degrees Fahrenheit or the laundry may be appropriately sanitized or disinfected by other acceptable methods. <u>Pets</u> k. Facility owned – Established policies regarding pet annual exam, vaccinations, prevention of spread of fleas, ticks, etc., and who is responsible for care. <u>Environmental Safety</u> l. Maintain the environment to protect the health and safety of clients by keeping surfaces smooth and free of sharp edges, mold and dirt; keeping floors free of unsafe objects and slippery or uneven surfaces and keeping the environment free of other conditions which may pose a potential risk to the health and safety of the clients.			a.
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				c.
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Facility Name:

		Met	Not Met
19-006.22 Continued	m. Maintain all doors, stairways, passageways, aisles or other means of exit in a manner that provides safe and adequate access for care and treatment		m.
	n. The inpatient facility provides water for bathing and hand washing at safe and comfortable temperatures to protect clients from the potential for burns and scalds.		n.
	<ul style="list-style-type: none"> Established policies to determine client's mental, physical, & psychological ability to protect himself/herself from injury due to hot water Method to monitor water temperature, client safety & preferences 		o.
	o. Established policies and procedures to ensure hazardous/poisonous materials are properly handled and stored to prevent accidental ingestion, inhalation, or consumption of the hazardous/poisonous materials by clients		p.
	<u>Disaster Preparedness and Management</u>		
	p. Established procedures to ensure that clients care and treatment, safety, and well-being are maintained during and following instances of natural disasters, disease outbreaks, or other similar situations		q.
	q. Established plans to move clients to points of safety or provide other means of protection in case of fire, tornado, or other natural disasters or the treat of ingestion, absorption, or inhalation of hazardous materials.		r.
	r. Established policies and procedures to ensure hazardous/poisonous materials are properly handled and stored to prevent accidental ingestion, inhalation, or consumption of the hazardous/poisonous materials by clients.		s.
	s. Evidence that the facility restricts access to mechanical equipment which may pose a danger to clients.		